IC 27-8-11

Chapter 11. Accident and Sickness Insurance–Reimbursement Agreements

IC 27-8-11-1

Definitions

Sec. 1. As used in this chapter:

"Health care services":

(1) means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization; and

(2) includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

"Insured" means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.

"Insurer" means an insurance company authorized in this state to issue policies that provide reimbursement for expenses of health care services.

"Person" means an individual, an agency, a political subdivision, a partnership, a corporation, an association, or any other entity.

"Preferred provider plan" means an undertaking to enter into agreements with providers relating to terms and conditions of reimbursements for the health care services of insureds, members, or enrollees relating to the amounts to be charged to insureds, members, or enrollees for health care services.

"Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

As added by P.L.140-1984, SEC.1. Amended by P.L.31-1988, SEC.22.

IC 27-8-11-2

Conflicting provisions

Sec. 2. To the extent of any conflict between this chapter and IC 27-4-1-4, IC 27-8-5-10, IC 27-8-5-15, IC 27-8-6-1, or any other statutory provision, this chapter prevails over the conflicting provision. Agreements may be entered into under section 3(a)(1) of this chapter notwithstanding any contradictory policy provision prescribed under IC 27-8-5-3(a)(9).

As added by P.L.140-1984, SEC.1.

IC 27-8-11-3

Reimbursement agreements; immunity

Sec. 3. (a) An insurer may:

(1) enter into agreements with providers relating to terms and conditions of reimbursement for health care services that may be rendered to insureds of the insurer, including agreements relating to the amounts to be charged the insured for services rendered or the terms and conditions for activities intended to reduce inappropriate care;

(2) issue or administer policies in this state that include incentives for the insured to utilize the services of a provider that has entered into an agreement with the insurer under subdivision (1); and

(3) issue or administer policies in this state that provide for reimbursement for expenses of health care services only if the services have been rendered by a provider that has entered into an agreement with the insurer under subdivision (1).

(b) Before entering into any agreement under subsection (a)(1), an insurer shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1). These terms and conditions may not discriminate unreasonably against or among providers. For the purposes of this subsection, neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties constitutes unreasonable discrimination. Upon request by a provider seeking to enter into an agreement with an insurer under subsection (a)(1), the insurer shall make available to the provider a written statement of the terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1).

(c) No hospital, physician, pharmacist, or other provider designated in IC 27-8-6-1 willing to meet the terms and conditions of agreements described in this section may be denied the right to enter into an agreement under subsection (a)(1). When an insurer denies a provider the right to enter into an agreement with the insurer under subsection (a)(1) on the grounds that the provider does not satisfy the terms and conditions established by the insurer for providers entering into agreements with the insurer, the insurer shall provide the provider with a written notice that:

(1) explains the basis of the insurer's denial; and

(2) states the specific terms and conditions that the provider, in the opinion of the insurer, does not satisfy.

(d) In no event may an insurer deny or limit reimbursement to an insured under this chapter on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an agreement with the insurer.

(e) No cause of action shall arise against any person or insurer for:

(1) disclosing information as required by this section; or

(2) the subsequent use of the information by unauthorized individuals.

Nor shall such a cause of action arise against any person or provider for furnishing personal or privileged information to an insurer. However, this subsection provides no immunity for disclosing or furnishing false information with malice or willful intent to injure any person, provider, or insurer.

(f) Nothing in this chapter abrogates the privileges and immunities established in IC 34-30-15 (or IC 34-4-12.6 before its repeal).

As added by P.L.140-1984, SEC.1. Amended by P.L.134-1994,

SEC.1; P.L.191-1996, SEC.1; P.L.1-1998, SEC.151; P.L.1-1999, SEC.59.

IC 27-8-11-3.1 Repealed

(*Repealed by P.L.1-1999, SEC.60.)*

IC 27-8-11-4

Accessibility and availability terms; reasonable standards

Sec. 4. Policies issued under section 3(a)(3) or section 3.1 of this chapter (before its repeal) may not contain terms or conditions that would operate unreasonably to restrict the access and availability of health care services for the insured. The commissioner of insurance may, under IC 4-22-2, adopt rules binding upon insurers prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies described in section 3(a)(3) or section 3.1 of this chapter (before its repeal).

As added by P.L.140-1984, SEC.1. Amended by P.L.134-1994, SEC.3; P.L.1-1999, SEC.61.

IC 27-8-11-4.5

Permitted disclosures by providers; coverage of benefit or service; payment of provider; application

Sec. 4.5. (a) An agreement between an insurer and provider under section 3 of this chapter may not prohibit a provider from disclosing:

(1) financial incentives to the provider;

(2) all treatment options available to an insured, including those not covered by the insured's policy.

(b) An insurer may not penalize a provider financially or in any other manner for making a disclosure permitted under subsection (a).

(c) An insured is not entitled to coverage of a benefit or service under a health insurance policy unless that benefit or service is included in the insured's health insurance policy.

(d) A provider is not entitled to payment under a policy for benefits or services provided to an insured unless the provider has a contract or an agreement with the insurer.

(e) This section applies to a contract entered, renewed, or modified after June 30, 1996.

As added by P.L.192-1996, SEC.1.

IC 27-8-11-5

Preferred provider plans; filing sworn statement

Sec. 5. Each person that organizes a preferred provider plan under this chapter shall file with the commissioner before March 1 of each year a statement, under oath, upon a form prescribed by the commissioner that covers the preceding calendar year and includes the following:

(1) The name and address of each person that has organized a preferred provider plan.

(2) The names and addresses of the providers with whom the preferred provider plan has entered into agreements under

section 3 of this chapter.

(3) The geographical area, by counties, within which the preferred provider plan provides or arranges for health care services for insureds, members or enrollees.

(4) The number of insureds, members or enrollees covered by the agreements listed in subdivision (2).

As added by P.L.31-1988, SEC.23.

IC 27-8-11-6

Preferred provider plans; hospital accreditation

Sec. 6. (a) A preferred provider plan may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

(b) This section does not prohibit a preferred provider plan from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

As added by P.L.259-1995, SEC.2.